

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045203

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3466

FILED DEC 7 1962

VS 300
Rev. 4/59

4000

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RATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) Koch		c. CITY OR TOWN St. Louis, Mo.	
Length of stay in 1b 38 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital		d. STREET ADDRESS (If outside, give location) 3719 Humphrey	
3. NAME OF DECEASED (Type or print) First Rose Middle Alice Last Cummiskey		4. DATE OF DEATH Month November Day 26 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-27-84
9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John D. Booth		13b. MOTHER'S MAIDEN NAME Rose Reynolds	
14. NAME OF HUSBAND-OR WIFE James T. Cummiskey(Dec'd.)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Records of Robert Koch Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Throat			INTERVAL BETWEEN ONSET AND DEATH Hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ruptured Aortic Aneurysm			Years
DUE TO (c) Arteriosclerosis			451x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 10-19-62 to 11-26-62 and last saw ^{her} alive on 11-26-62 Death occurred at 9:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Bernard Friedman (Degree or title) M.D.		22b. ADDRESS Robert Koch Hospital - Koch, Mo.	
22c. DATE SIGNED 11-26-62		23. LOCATION (City, town, or county) (State) St. Louis, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 28, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. 11-27-62	
26. REGISTRAR'S SIGNATURE J. M. Murphy		27. REGISTRAR'S SIGNATURE J. M. Murphy	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James R. Dunn

Licensed Embalmer No. 4527

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.